San Antonio Uniformed Services
Health Education Consortium
San Antonio, Texas

San Antonio Uniformed Services Health Education Consortium (SAUSHEC) Trainee Supervision Policy

I. Applicability

The SAUSHEC Command Council (Commanders of Brooke Army Medical Center [BAMC] and Wilford Hall Medical Center [WHMC] and the Dean SAUSHEC) and the Graduate Medical Education Committee (GMEC) of SAUSHEC have approved this policy. It applies to all staff physicians, dentists, program directors and trainees of SAUSHEC's member hospitals (BAMC and WHMC) and establishes minimum requirements for supervision of trainees who provide medical care to patients at these hospitals. This instruction applies to all personnel assigned, attached, or on contract to BAMC and WHMC. SAUSHEC Graduate Medical Education (GME) program directors will also comply with any additional supervision requirements of their respective Residency Review Committees (RRCs) or accrediting organizations.

II. Definitions and responsibilities.

A. A trainee is defined as a medical**,** dental, physical therapy, dietetic, etc. intern**;** resident or fellow who has graduated from a medical, dental, physical therapy, dietetic, etc. school respectively, and is either in the first or subsequent post graduate training program in a specialty or subspecialty.

B. A student is someone who is currently enrolled in a medical/osteopathic, dental, physician assistant, physical therapy, etc. school.

C. A supervising staff provider is a licensed independent practitioner (LIP) who is credentialed to supervise trainees and students. This is an individual with appropriate training and an unrestricted state license who has privileges in a field, specialty or subspecialty of medicine or dentistry that would allow that individual to practice without supervision at BAMC or WHMC. LIPs may supervise trainees and students in the areas of medical/dental care in which they are privileged, if they are approved to do so by the appropriate Program Director. It is supervising staff providers (LIPs) that are ultimately responsible for all aspects of their patient's care within each SAUSHEC training hospital.

D. "Supervision" constitutes any method of staff oversight of patient care for the purpose of ensuring quality of care and enhancing learning; this term does not necessarily require the physical presence or the independent gathering of data about the patient on the part of the supervising staff provider.

E. The term "team" refers to that group of trainees and staff who share responsibility for the care of a given patient.

F. The term "acutely ill" refers to a patient with a condition that is reasonably expected to threaten life, limb, or major organ function within 24 hours.

G. The term "major surgical case" is defined as a procedure that enters a major body cavity or has more than a negligible potential for morbidity or mortality. Any procedure performed on a patient with major risks from sedation/anesthesia due to underlying medical problems may also be considered a major case.

H. Institutional Clinical Authority (ICA) is the institutional official designated in MTF documents as having responsibility for the quality of care provided by LIPs and trainees at that MTF.

I. San Antonio Uniformed Services Health Education Consortium (SAUSHEC) is the GME sponsoring institution for BAMC & WHMC. The Command Council of SAUSHEC is the Institutional Governing Body (IGB) for military GME in San Antonio. Voting Members of the Command Council are the Commanders of WHMC and BAMC with the Dean of SAUSHEC as a non-voting member. The Command Council is ultimately responsible for GME program needs and obligations in planning , decision-making, providing necessary resources to programs, and ensuring appropriate resident supervision.

J. Designated Institutional Official (DIO) is the GME individual recognized by the ACGME and SAUSHEC as having the authority and the responsibility for oversight and administration of the SAUSHEC GME programs. This person is called the Dean of SAUSHEC.

K. The SAUSHEC Graduate Medical Education Committee (GMEC) is composed of the DIO (who is the Chair), Associate Deans, Program and Associate Program Directors, peer selected resident representatives, and faculty appointed by the Dean. The GMEC approves all institutional GME policies and actions.

L. Program Directors are the institutional officials designated by SAUSHEC and recognized by the RRCs as having direct responsibility for all training activities within their training program. Program Directors are directly responsible for the quality of educational experiences provided to trainees and appropriate resident supervision.

III. General Principles of Supervision.

A. Careful supervision and observation are required to determine the trainee's ability to gather and interpret clinical information, perform technical procedures, interpretive procedures and to safely manage patients. Although not privileged for independent practice, trainees must be given graded levels of patient care responsibility while concurrently they must be supervised to assure quality care for patients. Each

patient must have a responsible attending whose name is recorded in the patient record, who is available to the residents, and who is involved with and takes responsibility for the patient care being done by the trainees he/she is supervising. Supervision of trainees should be organized so as to provide gradually increased responsibility and maturation into the role of a judgmentally sound, technically skilled, and independently functioning privileged provider**.** Each SAUSHEC program director will define policies that specify how trainees in that program progressively become independent in specific patient care activities in his/her program while still being appropriately supervised by medical staff. Typically this involves a job description for each year of training. The Program Director will also define the evaluation methods used to determine when a resident can progress to the next level of training and when they are competent to graduate.

B. Training program supervision policies must be in compliance with this SAUSHEC policy, the bylaws of the Medical Staff of each MTF and with ACGME/RRC/JCAHO policies on resident supervision. Furthermore, Medical Staff governing bodies of BAMC and WHMC routinely update attending staff responsibilities as they pertain to the supervision of residents. Program supervision policies will delineate the role and responsibilities and patient care activities of trainees. These policies should include such items as which trainees may write patient care orders, the circumstances under which the trainee may do so, and what entries, if any, must be countersigned by a supervisor (either a staff or a more senior resident). Ultimately, the supervising staff is responsible for the care of the patient and for the conduct and performance of all trainees under his/her supervision. Exceptions to this may occur when a trainee willfully disregards SAUSHEC/hospital/program policy or the directions of a staff supervisor; conceals his/her intentions or actions from a staff or supervisor; performs medical care outside the scope of normally delegated responsibility without the knowledge and approval of the supervisor; or fails to appropriately perform duties that would generally be expected at his/her level of training without staff knowledge of the specific activities. The program director will insure that all supervision policies are distributed to and followed by trainees and the medical staff supervising their trainees. Supervision policies are also available on the SAUSHEC website.

C. Compliance with resident supervision policies will be monitored by the Program Directors who will report any issues to the GMEC, at least annually in their Metric reports and during scheduled internal reviews. Any problematic issues will be reported to the governing bodies of BAMC & WHMC by the Dean. At the end of each academic year, the Program Director will determine if residents are prepared to progress to the next level of training. This assessment will be documented in the Program Director's annual assessment of each resident.

D. The GMEC will have representation at appropriate sponsoring institution patient care and patient safety committees. This representation will insure communication on resident supervision and patient safety issues occurs between the GMEC and the Organized Medical Staff and hospital governing bodies.

IV. Trainee Supervision in Different Patient Care Settings

A. Supervision of trainees on Inpatient Ward/ICU Teams.

1. All lines of authority for inpatient care delivered by inpatient ward/ICU teams will be directed to one privileged staff provider (usually known as the "attending") who will be clearly identified in the medical record. The attending staff provider has the primary responsibility for the medical diagnosis and treatment of the patient. In the interest of continuity of care and effective trainee supervision, inpatient staff rotational schedules should minimize the number of different staff providers to provide daytime coverage for any one inpatient, typically no more than two in any given week. Trainees may write daily orders on inpatients for whom they are participating in patient care, and these orders will be implemented without the co-signature of a staff physician unless there is a specific restriction in the hospital or ward order writing policy (e.g. chemo therapy orders etc). It is the responsibility of the resident to discuss all orders with senior supervising residents &/or the attending staff physician. Attending staff may write orders on all patients under their care. Trainees will follow all specific BAMC or WHMC policies and the policies of each patient care area for writing orders, including when and how to notify nurses and the appropriate procedure for verbal orders.

2. General job descriptions, supervision and documentation plans by training year for residents on **inpatient** services are outlined below. These may be modified by program/service specific job descriptions but they may not be less restrictive. Inherent in the duty of all resident physicians is the absolute responsibility to communicate with the attending staff in an expeditious fashion regarding any changes in the status of the patients under their care or any issues that arise that might potentially impact patient treatment or wellbeing.

a. The PGY1 can

(1) Take a complete H&P on new admissions (unless otherwise specified by a particular teaching service) and document them in the patient's chart using approved hospital forms or electronic methods. After discussion with the attending physician and/or supervising resident, the PGY1 can write an assessment and initial management plan and institute approved therapeutic interventions.

(2) Under the supervision of a more senior resident and/or the attending physician, conduct work rounds, write progress notes which include an interim history and physical exam, laboratory and radiographic data, and an assessment and plan. If a significant new clinical development arises, there must be timely communication by a member of the resident team with the attending physician.

(3) Completion of discharge summaries unless otherwise specified by the Program/service.

(4) Write transfer notes and acceptance notes between critical care units and floor units (unless otherwise specified by the Program/service) after appropriate

guidance from a senior resident or attending physician. Such transfer notes shall summarize the hospital course and list current medication, pertinent laboratory data, active clinical problems and physical exam findings. The attending physician must be involved in any such transfer.

(5) Write an "off-service" note summarizing the pertinent clinical data about the patient to the oncoming team unless the Program/service has another mechanism to assure communication of patient care data. The new resident team must notify the attending physician of the change in resident teams and review the management plan with him/her.

b. The PGY2 of an inpatient teaching team can (unless otherwise specified by the program or service):

(1) Take responsibility for organizing and supervising the teaching service in concurrence with the attending physician and provide the junior residents and medical students under their supervision a productive educational experience. Work directly with the PGY1's in evaluating all new admissions, and reviewing all H&P's, progress notes and orders written by the intern. The PGY2, in consultation with the attending physician, can supervise interns performing procedures that the PGY2 is deemed qualified to perform. PGY2s may perform any of the PGY1 tasks outlined above at the discretion of the attending or patient care area policies.

(2) PGY2 residents must maintain close contact with the attending physician of each patient and notify him/her as quickly as possible of any significant changes in the patient's condition or therapy. The physician of record must approve, in advance (except for emergency situations), all significant invasive procedures, costly imaging modalities or those with significant patient risk, and all significant therapy decisions or changes in treatment.

c. The PGY3 (and above) of an inpatient teaching team can (unless otherwise specified by the program/service):

(1) Perform all duties of the PGY2 outlined above when acting in a similar supervisory capacity, and at the discretion of the attending physician or patient care area policies.

(2) Provide assistance with difficult cases, and provide instruction in patient management problems when called upon to do so by other residents. They can assume direct patient care responsibilities when needed to assist more junior residents during times of significant patient volume or severity of illness.

d. The PGY4 and above resident of an inpatient teaching team can (unless otherwise specified by the program /service):

(1) Perform all the duties of the more junior residents at the discretion of the attending physician or patient care area policies.

(2) Act in the capacity of a "Junior Attending" under the supervision of the attending physician of record. This provides the senior resident the opportunity to receive progressive responsibility for patient care in longer training programs while still receiving supervision appropriate for level of training. The Senior resident must fully understand his/her responsibility to discuss all patient care decisions with the attending of record, and to ensure that the attending physician is fully aware of all treatment plans and pertinent patient care issues.

3. Documentation of Staff supervision of Patient Care for hospitalized patients.

Staff supervision of patient care must be documented in the inpatient record. Date, time, signatures, and signature stamps (or printing of names to clearly identify the individual) are required on all notes and orders if not performed electronically. Documentation requirements for inpatient care are outlined below.

a. Documentation that must be performed by staff:

(1) For all non short form inpatient admissions, there must be documentation in writing (dated and timed) by the attending physician noting that he/she has seen the patient, reviewed the case with residents and the attending's concurrence with the resident's history, physical examination, assessment, treatment plan and orders within 24 hours of admission. Prior to anesthesia (other than local), surgery or any major invasive procedure the resident history and physical examination must be signed, dated and timed by the attending physician reflecting the attending physician's concurrence with the exam *in advance* of the procedure performed. In addition, the record must contain an attending note, (separate from the resident History and Physical) dated and timed prior to performance of any major procedure that states the attending physician has seen the patient and concurs with the History and Physical as written in the record and agrees with the assessment and plan as written in the record. For emergent or urgent situations that require action prior to the physical presence of the attending, the senior in-house resident must clearly state in the medical record that the attending physician (after discussion by phone) is aware of the procedure and agrees with the plan and the need to proceed ASAP. This note must be dated and timed prior to the procedure. The attending physician should sign this note as soon as physically possible and time and date his/her signature.

(2) For short form admissions staff must co-sign the short form history and physical or its equivalent on the Abbreviated Medical Record within 24 hours of admission.

(3) Document concurrence with major therapeutic decisions, such as "Do Not Resuscitate" status, by specific mention in a staff written progress note.

(4) Staff notes are required at least daily for all ward and ICU patients and as needed to note any significant change in patient status or change in plan. Staff to staff discussion and written staff documentation is generally required for the transfer of any patient into the ICU or for the transfer of the patient to the care of another attending physician.

(5) All notes by medical or dental students must be reviewed and co-signed (indicating agreement with content of student note) by a staff provider if not previously signed by a resident.

b. Documentation done by trainees:

(1) Trainees must document their patient care and the fact that they are being supervised by writing progress notes and/or co-signing notes written by medical or dental students. The condition of the patient determines how often progress notes are written. Trainee progress notes are written at least daily on all patients who are acutely ill or are less than five days out from major surgery.

(2) Documentation of staff supervision can be accomplished in the trainee note by including statements like "Dr. Smith (the attending) is aware and concurs with…") in the following situations:

(a) For admissions to critical care units, there must be documentation of notification of the admission and concurrence of the staff or fellow with trainee health care plans within four hours of admission.

(b) For emergent or urgent situations that require action prior to the physical presence of the attending, the senior resident must clearly state in the medical record that the attending physician (after discussion by phone) is aware of the plan/procedure and agrees with the need to proceed. This note must be dated and timed prior to the proposed procedure, and the attending physician should sign this note as soon as physically possible and date and time his/her signature.

(c) Documenting staff concurrence with discharge plans before the patient is discharged.

(d) Documenting staff concurrence with decision to transfer patient to another provider, service or facility.

(e) Documenting staff concurrence with issues dealing with Advance Directives, informed consent and refusal of care.

B. Supervision of Trainees on Inpatient Consult Teams.

All inpatient consultations performed by trainees will be documented in writing with the name of the responsible staff consultant recorded. The responsible staff consultant must

be notified verbally by the trainee performing the consult within an appropriate period of time as defined by the particular consulting service. The consulting staff is responsible for all the recommendations made by the consultant team. If requested by the patient's primary staff, the consulting staff must see the patient in a timely manner that is agreeable to both the referring and consulting staff.

C. Supervision of Trainees in the Operating room.

1. The staff physician must be present in the operating room area for the critical parts (including patient and operative site identification) of all major cases. A major case is defined as a procedure that enters a major body cavity or has potential for mortality, significant morbidity or significant blood loss. Any procedure performed on a patient with major risks from sedation/anesthesia due to underlying medical problems will be considered a major case. In some cases, even positioning of the patient may be considered a critical part of an operation in an unstable patient.

2. If, in the opinion of the staff, a surgical procedure is minor or of low potential for significant morbidity, and if the resident is deemed competent to perform the procedure without immediate supervision, (as defined in the training program's curriculum) the resident may proceed as directed after proper patient and operative site identification. However, even in his or her absence from the operating room area, the staff physician remains responsible for all aspects the patient's care.

D. Supervision of Trainees in Outpatient clinics.

All outpatient visits provided by trainees will be done under the supervision of a staff provider. This staff provider will interview and examine the patient at the staff's discretion, at the trainee's request, or at the patient's request. The staff doctor has full responsibility for care provided, whether or not he/she chooses to personally verify the trainee interview, examination or laboratory data. However, the resident physician can reasonably be expected to provide treatment for patients commensurate with their level of training and as directed by the attending physician. The name of the responsible supervising staff will be clearly recorded in the patient or clinic records.

E. Supervision of Trainees in the Emergency Department.

1. The responsibility for supervision of trainees providing care in the Emergency Department will be identical to that outlined for supervision of trainees in outpatient clinics (D above).

2. The supervision of trainees who are called in consultation on patients in the ED will be identical to that outlined in the scheme for inpatient consultation supervision (B above). Consulting staff should be promptly notified by the residents of any ED consultation.

F. Supervision of Trainees in interpretive settings.

Trainees who do primarily interpretation of laboratory tests, imaging studies or pathology specimens must also undergo documented supervision. It is the responsibility of each training program/department in these areas to establish supervisory regulations in compliance with JCAHO & RRC requirements.

V. Supervision of Trainees performing Conscious sedation and invasive procedures.

A. Conscious sedation will only be performed in the appropriate setting (i.e., where adequate patient monitoring is available, where resuscitation can be readily performed, etc.) and only under the *direct* supervision of a Licensed Independent Practitioner who is qualified to perform conscious sedation. The Conscious Sedation Policy for each institution must be followed.

B. A trainee will be considered qualified to perform an invasive procedure without direct line of sight supervision if, in the judgment of the supervising staff (and according to his/her specific training program guidelines), the trainee is competent to safely and effectively perform the procedure. Residents at certain year levels in a training program may be designated as competent to perform certain procedures under indirect supervision based upon specific criteria defined by the program director. Trainees may perform procedures that they are deemed competent to perform for standard indications without prior approval or direct supervision of staff, provided that the staff is notified in a timely fashion. The patient's staff of record will be ultimately responsible for all procedures performed on patients. Residents may perform emergency procedures without prior staff approval when life or limb would be threatened by delay. In this case the most senior trainee available will perform or supervise the procedures.

C. All procedures will have the staff of record documented in the procedure note and the identified staff will ultimately be responsible for the procedure.

D. Students will not perform procedures without direct supervision of an LIP or a resident qualified to perform the procedure.

VI. Supervision in Emergency Situations.

A. An "emergency" is defined as a situation where immediate care is necessary to preserve the life of, or to prevent serious impairment to the health of a patient.

B. In such situations, any resident is expected to do everything possible to save the life of a patient or to save a patient from serious harm. Residents will make all reasonable efforts to obtain assistance from more senor residents and/or any staff available in the hospital and will contact the appropriate attending as soon as possible.

C. The resident will document all aspects of any emergency patient care rendered, (including who was contacted) in the patient's record.

VII. Trainee grievances regarding supervision.

A. It is the Program Director's responsibly to insure that trainees are aware that any concerns they have regarding adequate technical or professional supervision, or professional behavior by their supervisors will be addressed in a safe & non-threatening environment per SAUSHEC and ACGME guidelines.

B. All SAUSHEC GME programs must follow SAUSHEC resident grievance policies. Trainee grievance mechanisms will be established for each Department/Training Program, and will be clearly stated and made available to all trainees during orientation to that Department/Program. These grievance mechanisms must ensure that fair and just relationships between students and teachers are perpetuated.